

MEDICAL APPROVAL FORM

NAME OF PARTICIPANT: _____ DATE _____

PHONE #: _____

The fitness center at West Hartford Senior Center provides a number of health/fitness activities, programs and services for the apparently healthy individual. We would appreciate it if you would signify your approval for their participation in this program by completing the following questions.

1. Has the patient experienced any of the following symptoms of CVD?

_____ Palpitations or abnormal heart rhythms

_____ Chest pain or pressure (angina type)

_____ Dizziness or faintness upon exertion

If so, please explain _____

2. Does the patient have any of the following CVD risk factors?

_____ Hypertension

_____ Hyperglycemia or diabetes mellitus

_____ Hypercholesterolemia of elevated blood lipids

_____ Cigarette smoking

_____ Family history of heart disease

_____ Obesity

_____ Sedentary lifestyle

_____ Tension / stress

3. List any musculoskeletal injuries or problems, such as arthritis, that may be aggravated by exercise or that may limit an exercise program.

4. Please indicate any heart, fluid, blood pressure, seizure, diabetic or an other pertinent medications taken on a regular basis, and maximum heart rate not to exceed during exercise where applicable:

Based on the preceding information, please indicate approval of the following exercises and equipment for use by filling in the appropriate boxes below.

_____ may participate in the following activities. Please use a (+) to indicate approval and a (o) to signify contraindicated.

_____ flexibility	_____ exercise bicycles
_____ walking program	_____ aerobics
_____ running /jogging	_____ low-impact
_____ Nordic Track ski simulator	_____ general swimming
_____ calisthenics	_____ lap swimming
_____ water aerobics	_____ free weights
_____ resistance machines	_____ stairmaster
_____ sauna and whirlpool	_____ elliptical cross trainer
_____ rowing machine	_____ Nustep recumbent stepper

Exceptions/ restrictions on above exercises _____

Recommend participation on the fitness program:

Full _____ Limited _____ (Comments, recommendations)

Physicians name (please print) _____

Signature _____ Phone _____